

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**163-042722**  
STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 379

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0017

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION *Dr. Green*

**FILED DEC 2 1963**

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>		Length of stay in 1b <b>years</b>	c. CITY OR TOWN <b>Kirksville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b># 7 Dear St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b># 7 Dears St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARL SAMUEL NOVINGER</b>			4. DATE OF DEATH Month Day Year <b>Nov, 25 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> <del>UNMARRIED</del>	8. DATE OF BIRTH <b>1/15/86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	9. AGE (last birthday) <b>77</b> If UNDER 1 YEAR: Months Days Hours Min. If UNDER 24 Hrs: Hours Min.
11. BIRTHPLACE (City and state or country) <b>Novinger, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>	
13a. FATHER'S NAME <b>Daniel D. Novinger</b>		13b. MOTHER'S MAIDEN NAME <b>Elnora Jane Bozarth</b>	14. NAME OF <del>husband</del> OR WIFE <b>Clara Morgan Novinger</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of serv) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Clara Novinger, Kirksville, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>One Hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Carcinoma of Bladder, treated.</b>			PART III. If deceased was female was there a pregnancy in last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month; Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>10-25-62</b> to <b>11-25-63</b> and last saw him alive on <b>11-25-63</b> Death occurred at <b>12:20</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>S. M. Green, M.D.</b>		22b. ADDRESS <b>Kirksville, Mo.</b>	22c. DATE SIGNED <b>11-25-63</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Nov. 27/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park</b>	23d. LOCATION (City, town, or county) (State) <b>Kirksville, Adair, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Foster Memorial Home, Kirksville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>11-26-63</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Rattliff</b>

No permit received

E. M. GRIM, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Nov E Foster*

Licensed Embalmer No.

4742

P. O. Address

*Fukemille, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.